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No.

IN THE

Supreme Court of the United States

DEERBROOK PAVILION, L.L.C.,
Petitioner,

vs.

DONNA E. SHALALA, ET AL.,
Respondent.

On Petition for a Writ of Certiorari to the
United States Court of Appeals for the Eighth Circuit

PETITION FOR WRIT OF CERTIORARI

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Questions Presented

I. What deference must courts afford to unpublished, internal agency memoranda interpreting statutes or regulations enforced by that agency?

II. Whether the Health Care Financing Administration has any authority to collect a civil money penalty from a successor operator of a nursing home that had no responsibility for the actions that led to the penalty?

Parties And Corporate Disclosure Statement

The parties to this action are:

Petitioner – Deerbrook Pavilion, L.L.C.

Respondents – Donna E. Shalala, Secretary, U.S. Department of Health & Human Services

United States Department of Health and Human Services

Nancy-Ann Min DeParle, Administrator, Health Care Financing Administration

Joe L. Tilghman, Regional Administrator, Health Care Financing Administration

Thomas W. Lenz, Associate Regional Administrator for Division of Medicaid and State Operations

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Gary J. Strangler, Director, Missouri Department of Social Services

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Missouri Division of Medical Services

Deerbrook Pavilion, L.L.C. is a Missouri limited liability company. It has no parent company and there are no publicly held companies that have a 10% or more interest in Deerbrook.

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Opinions Below

The District Court's opinion is unreported. The opinion of the Court of Appeals is reported at 235 F.3d 1100 (8th Cir. 2000).

Jurisdictional Basis

The Court of Appeals issued its opinion on December 26, 2000. App. 1. On February 9, 2001, Deerbrook Pavilion, L.L.C. (Deerbrook) filed a timely petition for rehearing en banc.[1] App. 10. On March 22, 2001, by a five to four vote, the Court of Appeals denied that petition. App. 24. The instant petition for certiorari is timely, in that Deerbrook has filed it within 90 days of March 22, 2001.

This Court has jurisdiction of this petition pursuant to 28 U.S.C. § 1254(1), in that Deerbrook seeks review of a final opinion of the United States Court of Appeals for the Eighth Circuit.

Statutes Involved

42 U.S.C. § 1395i-3(h) and 42 U.S.C. § 1320a-7a are the relevant statutes. Pursuant to Rule 14.1(f) of this Court's Rules, these statutes are set forth in the appendix. App. 25.

Statement Of The Case

To participate in the Medicare or Medicaid program, a facility must have a provider agreement. In 1996, an entity known as Deerbrook Nursing Center, Inc. (Origi-

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1 Because a federal officer is party to the appeal, Rule 40(a)(1), Fed. R. App. P., allowed Deerbrook 45 days from the date of the opinion to file its petition for rehearing.

nal Operator) had a provider agreement for a skilled nursing facility which it leased from the owner. Original Operator and Deerbrook have no common owners, directors, or principals. In April 1996, the Missouri Division of Aging concluded that Original Operator did not comply with various health and safety standards. As a result, the Health Care Financing Administration (HCFA) assessed a civil money penalty against Original Operator.

In July 1996, the lessor terminated Original Operator's lease. An entity known as Deerbrook Healthcare, Inc. (Successor Operator) took over the facility and assumed the provider agreement. Successor Operator and Deerbrook have no common owners, directors, or principals. Successor Operator restored the facility to acceptable levels of care and HCFA ended the civil money penalty in September 1996. The penalties against Original Operator and Successor Operator totaled $419,700. None of those penalties were assessed against Deerbrook, and Deerbrook had no responsibility for the conduct that led to them.

In January 1997, the lessor terminated Successor Operator's lease, and Deerbrook took over the facility and assumed the provider agreement. Two and a half years later, in July 1999, HCFA informed Deerbrook that Deerbrook, as successor to Original Operator and Successor Operator, was responsible for the entire $419,700 civil money penalty.

The basis for HCFA's position is neither a statute nor a regulation. Rather, it is an informal memorandum (the Tirone memorandum), App. 31, written in 1994 by Anthony Tirone, a HCFA bureaucrat. The Tirone memorandum does not identify Mr. Tirone's status within

HCFA nor any of the information on which he based his conclusions. HCFA has never published the Tirone memorandum.

Pursuant to the Tirone memorandum, HCFA withheld approximately $29,000 in reimbursements owing to Deerbrook. Later in 1999, an entity known as White Oak Terrace took over the facility and assumed the provider agreement. In its brief in the Court of Appeals, HCFA argued that this assumption mooted the case, because Deerbrook would no longer be liable for the unpaid penalty. Thus, HCFA's policy is that assignment of the provider agreement divests the predecessor of any liability for any unpaid civil money penalties and transfers that liability to the successor.

No statute expressly authorizes HCFA to collect a civil money penalty from a successor. The statute under which it purported to act allows HCFA to deduct penalties from sums "due to the person against whom the penalty or assessment has been assessed." 42 U.S.C. § 1320a-7a(f). Since no penalty was assessed against Deerbrook, that statute does not authorize HCFA to collect it from Deerbrook.

Similarly, no regulation expressly authorizes HCFA to collect a civil money penalty from a successor. 42 C.F.R. § 489.18 provides that the successor takes the provider agreement "subject to all applicable statutes and regulations and to the terms and conditions under which it was originally issued." This begs the question whether a civil money penalty *is* one of the "terms and conditions" of the original provider agreement, and whether the "applicable statutes and regulations" so provide.

The Tirone memorandum does not, in so many words, adopt a policy of successor liability for civil money penalties. Rather, it recites that HCFA had *proposed* to *consider* a rule that would so provide. App. 36-37, *citing* 59 Fed. Reg. 20387 (April 25, 1994). The Tirone memorandum corrects an error in the abstract of the proposed rule. Beyond that, "we can say nothing more except that we expect the [notice of proposed rulemaking] to be published in the Federal Register in several months, and that there will be a 60-day public comment period." App. 37. Those expectations were not realized. HCFA did not publish any notice of proposed rulemaking or any proposed formal rule, nor did it ever adopt any such rule.

Thereafter, HCFA twice indicated an *intention* to propose a formal rule under which civil money penalties would be "automatically assigned to a new owner." 61 Fed. Reg. 23008 (May 13, 1996); 64 Fed. Reg. 21266 (April 26, 1999). On neither of these occasions did HCFA even propose a formal rule, let alone adopt one.

Thus, the Tirone memorandum interprets not a regulation, but a proposed regulation that was never enacted. Nonetheless, the opinion of the Court of Appeals held that the Tirone memorandum was an agency's construction of its own regulations and therefore entitled to "great deference." App. 7 Accordingly, the Court of Appeals deferred to the Tirone memorandum.

Without such deference, the Court of Appeals surely would have reached the opposite result. Its casual assumption that *United States v. Vernon Home Health Care, Inc.*, 21 F.3d 693 (5th Cir.), *cert. denied*, 513 U.S. 1015 (1994), presents a "virtually identical issue," App. 7, proves only that the Court was not engaging in

meaningful judicial review. In *Vernon*, HCFA made interim payments to a home health provider based on the estimated cost of the services provided, subject to a year-end adjustment. *Vernon* held that a successor was liable for overpayments to the predecessor. The reason was that 42 U.S.C. § 1395g(a) authorized HCFA to make "necessary adjustments on account of previously made overpayments." The explicit basis for the *Vernon* holding was that the successor took the provider agreement "subject to the relevant statutory and regulatory conditions," one of which was that "adjustments are made for overpayments." 21 F.3d at 696.

Had the Court of Appeals engaged in meaningful review, instead of deferring blindly to the Tirone memorandum, it would have realized that there is no similar statutory basis for collecting civil money penalties from successors. On the contrary, § 1320a-7a(f) permits HCFA to collect such penalties by withholding monies due to "the person against whom the penalty has been assessed." A successor is not a person "against whom" any penalty has been assessed.

Deerbrook filed a timely petition for rehearing en banc. App. 10. By a vote of five to four, the Court of Appeals denied the petition. Judges Bowman, Loken, Bye and Morris S. Arnold dissented. App. 24

Argument

I. The Opinions Of This Court And The Court Of Appeals Are In Total Disarray On The Deference Due To Informal Agency Action Interpreting Agency Regulations Or The Statutes On Which They Rest.

Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837 (1984), holds that courts must afford a formal regulation "controlling weight" unless it is "arbitrary, capricious, or manifestly contrary to the statute." 467 U.S. at 844. *Chevron* deference also applies to a formal adjudication by the agency, as in *INS v. Aguirre-Aguirre*, 526 U.S. 415, 424 (1999).

Agencies also interpret statutes or regulations in informal ways – policy statements, interpretive guidelines, opinion letters, or – as here – internal memoranda. The deference due to such informal agency action is the subject of irreconcilable dispute, both in this Court and in the courts of appeals.

In this Court, one line of authority holds that the deference due to informal agency action depends on the reliability of the process that produced it. The starting point for this line of authority is *Skidmore v. Swift & Co.*, 323 U.S. 134 (1944). In *Skidmore*, the agency had issued interpretive bulletins and informal rulings, none of which answered the precise question before that Court. In an amicus brief, the agency argued that those informal actions suggested the result. The Court held that such informal agency action was "not controlling upon the courts." 323 U.S. at 140. Rather, it constituted "a body of experience and informed judgment" to which the courts could resort:

> The weight of such a judgment in a particular case will depend upon the thoroughness evident in its consideration, the validity of its reasoning, its consistency with earlier and later pronouncements, and all those factors which give it power to persuade . . . .

Id.

Post-*Chevron* decisions in which the Court applied *Skidmore* deference instead of *Chevron* deference to informal agency action include *Martin v. Occupational Safety and Health Review Com'n*, 499 U.S. 144, 157 (1991) (interpretive rules and enforcement guidelines are "not entitled to the same deference as norms that derive from the exercise of the Secretary's delegated lawmaking powers"); *EEOC v. Arabian American Oil Co.*, 499 U.S. 244, 257-58 (1991) (policy guideline's "persuasive value is limited when judged by the standards set forth in *Skidmore*"); and *Christensen v. Harris County*, 529 U.S. 576, 587 (2000) ("opinion letters – like interpretations contained in policy statements, agency manuals, and enforcement guidelines . . . do not warrant *Chevron*-style deference").

Another line of authority holds that *Chevron* deference applies as much to informal agency action as to any other. This line of authority dates to *Bowles v. Seminole Rock & Sand Co.*, 325 U.S. 410 (1945), in which the agency issued an interpretive bulletin simultaneously with the regulation. Although it cited no authority, *Seminole Rock* held that the agency's interpretation of its regulation is "of controlling weight unless it is plainly erroneous or inconsistent with the regulation." 325 U.S. at 414.

Since its 1984 decision in *Chevron*, the Court has issued numerous opinions affording *Chevron* deference to informal agency action. *E.g.*, *Lyng v. Payne*, 476 U.S. 926, 939 (1986) (publicity directive originally issued as a staff instruction is "entitled to substantial deference"); *Robertson v. Methow Valley Citizens Council*, 490 U.S. 332, 358-59 (1989) (agency construction of conditions in a permit "is not plainly erroneous or inconsistent with

the regulation, and is thus controlling") (citations and internal punctuation omitted); *Auer v. Robbins*, 519 U.S. 452, 461-62 (1997) (agency's interpretation in amicus brief before the Court is "controlling unless plainly erroneous or inconsistent with the regulation") (citations and internal punctuation omitted).

Some opinions treat *Chevron* deference and *Skidmore* deference as equivalents. In *Bragdon v. Abbott*, 524 U.S. 624 (1998), the Court afforded *Skidmore* deference to administrative opinions of several agencies, *id.* at 642, and *Chevron* deference to an administrative guideline promulgated by the Department of Justice. *Id.* at 646.

With the Court's precedents in this kind of disarray, it is hardly surprising that the federal circuit courts have reached inconsistent results. In the Eighth Circuit, one line of authority holds that "an agency's interpretation which is not subjected 'to the rigors of notice and comment' is not entitled to substantial deference." *In re Old Fashioned Enterprises, Inc.*, 236 F.3d 422, 425 (8th Cir. 2001), *quoting King v. Morrison*, 231 F.3d 1094, 1096 (8th Cir. 2000).[2] Other Eighth Circuit opinions, like the one in the instant case, afford full *Chevron* deference to informal agency action. *Love v. Tippy*, 133 F.3d 1066, 1069 (8th Cir.), *cert. denied*, 524 U.S. 956 (1998); *Vue v. INS.*, 92 F.3d 696, 699 (8th Cir. 1996). Neither of these lines of authority even acknowledges the existence of the other.

Opinions in the other circuits are equally at war with each other. *Compare Kavanagh v. Grand Union Co.*,

2 By an extraordinary coincidence, *King* was argued on the same day as the instant case, to the same panel, and Judge Heaney wrote both opinions.

192 F.3d 269, 272 (2d Cir. 1999) (affording *Chevron* deference to informal interpretive guideline); *Elizabeth Blackwell Health Center for Women v. Knoll*, 61 F.3d 170, 182 (3d Cir. 1995), *cert. denied*, 516 U.S. 1093 (1996) (*Chevron* "deference is appropriate here even though the Secretary's interpretation is not contained in a 'legislative rule'"); and *Your Home Visiting Nurse Services v. Secretary of Health & Human Services*, 132 F.3d 1135, 1139 (6th Cir. 1997), *aff'd*, 525 U.S. 449 (1999) (if Medicare Manual's interpretation of the statute is reasonable, "we must defer to it pursuant to *Chevron*"), *with New York City Employees' Retirement System v. SEC*, 45 F.3d 7, 13 (2d Cir. 1995) (informal no-action letter does not receive "the same high level of deference that is accorded formal policy statements or rule-making orders"); *Pennsylvania Medical Society v. Snider*, 29 F.3d 886, 902-03 (3d Cir. 1994) (applying *Skidmore* deference rather than *Chevron* deference to interpretive rule); and *Orr v. Hawk*, 156 F.3d 651, 655 (6th Cir. 1998) (informal agency action is "akin to an internal rule entitled only to limited deference").

Even the D.C. Circuit, with its special expertise in administrative law, has conflicting precedents. *Compare Damsky v. FCC*, 199 F.3d 527, 535 (D.C. Cir. 2000) (deferring to agency's interpretation of its "own rules and policies," and sustaining that interpretation "unless it is plainly erroneous or inconsistent with the regulation") (citations and internal punctuation omitted), *with Metropolitan Washington Airports Auth. v. United States*, 959 F.2d 297, 302 (D.C. Cir. 1992) ("[a]s we do not know who Mr. Hobart is, nor what information, parties or arguments he had before him, we can hardly treat this as an authoritative agency interpretation").

Agency actions play an increasingly important role in American law. This Court's competing lines of cases – *Chevron* and its progeny on the one hand, *Skidmore* and its progeny on the other – have created substantial confusion about the deference due to an unpublished, internal agency memorandum. Because the Tirone memorandum was central to the Eighth Circuit's opinion and because that opinion effectively gave the memorandum the force of law, this case presents a perfect opportunity for the Court to end the confusion over what deference such a memorandum merits.

II. Affording *Chevron* Deference To Informal Agency Action Destroys Any Institutional Check On The Powers Of An Administrative Agency.

Because of the complexity of modern regulatory schemes, Congress has given administrative agencies greater and greater discretion to make policy. So long as Congress identifies some intelligible principle to govern the exercise of that power, "we have almost never felt qualified to second-guess Congress regarding the permissible degree of policy judgment" assigned to such agencies. *Whitman v. American Trucking Ass'n*, 531 U.S. 457, 149 L.Ed.2d 1, 18 (2001) (citations and internal punctuation omitted). It is essential to a system of ordered liberty that administrative agencies exercise their powers in accordance with the methods Congress has prescribed, so that the agency faces institutional checks and balances.

The legal basis for *Chevron* deference is "congressional delegation of administrative authority." *Adams Fruit Co. v. Barrett*, 494 U.S. 638, 649 (1990). When an agency acts formally – when it adjudicates a dispute

with a binding order or enacts a regulation – it is clear that Congress has authorized the agency to make policy. *See, e.g.*, 5 U.S.C. §§ 553, 554. Congress has not authorized agencies to make binding policy in informal ways such as the Tirone memorandum. Cases implying a contrary rule do not explain:

> why, consistent with the underlying logic of delegation, an agency should be entitled to mandatory deference when it interprets a statute in a procedural format that does not otherwise have the force of law. If *Chevron* deference rests on an implied delegation of interpretational power, then this deference should not extend beyond agency action undertaken pursuant to the underlying grant of governmental power that gives rise to the implied delegation.

T. Merrill & K. Hickman, *Chevron's Domain*, 89 Geo. L. J. 833, 884 (2001).

As Merrill & Hickman observe, "powerful process considerations" support this view. *Id.* When an agency acts formally, the process provides an institutional check on irrational action. If the agency makes policy by adjudication, the affected party has the right to cross examine the agency's witnesses, to present its own evidence, and to receive a reasoned opinion from a neutral administrative law judge. If the agency proceeds by notice and comment rulemaking, "all potentially affected members of the public" have "an opportunity to participate" in the process. K. Davis & R. Pierce, *Administrative Law Treatise*, § 6.7 at 262 (3d Ed. 1994). That participation lets the agency make a truly informed decision on a complete factual record:

> [P]arties have incentives to include in their comments studies and affidavits of experts addressing such issues as (1) the frequency of occurrence of various factual patterns, (2) the likely efficacy of alternative rules in shaping conduct, (3) the cost of compliance with alternative rules, and (4) the practical problems inherent in implementing or enforcing alternative rules in varying factual contexts.

Id. Since the agency must provide a "reasoned response" to these comments "to avoid a judicial remand," there is a real institutional check on the agency's power. Merrill & Hickman, *supra*, 89 Geo. L. J. at 885.

When the agency makes policy in informal ways, however, there is no such process to provide accountability:

> A related process concern is the danger of the evasion of the procedural protections of the APA if Chevron deference is extended beyond legislative rules and binding adjudications. Agencies are often frustrated by the time and resources required to comply with notice-and-comment rulemaking and the rules of binding adjudication. Yet the APA and due process demand compliance with these procedures before agencies can take action that binds the public with the force of law.

Id.

When an agency acts informally, meaningful judicial review is the only way to provide any institutional check on agency discretion. Affording *Chevron* deference to

such action means that no one ever gives a hard look to the agency's decision. If no institutional mechanism provides accountability, the agency can act as arbitrarily as it wishes. It is precisely for this reason that Davis & Pierce reject *Chevron* deference for informal agency action:

> Congress has not delegated to any agency the power to make policy decisions that bind courts and citizens through formats like letters, manuals, guidelines and briefs. No court should allow an agency to bind citizens or court by applying *Chevron* step two to agency policy decisions announced in formats Congress has not authorized for that purpose.

K. Davis & R. Pierce, *supra*, § 3.5 at 120.

The instant case is a perfect illustration of the disaster that can result when agencies make policy without meaningful safeguards. HCFA's policy relieves the irresponsible prior operator of any liability for an unpaid civil money penalty – and transfers that liability to the entirely innocent successor. That policy may make it easier for HCFA to collect penalties. The objective of the civil money penalty however, is not to make it easy to collect the penalty, but to "ensure prompt compliance with program requirements." 42 C.F.R. § 488.402(a). No one (including the court of appeals) has ever explained how relieving the real culprit of all liability for its misconduct can possibly motivate that culprit to clean up its act.

The Eighth Circuit's opinion is further evidence of how foolish it is to afford *Chevron* deference to informal

agency action. That opinion rests on a number of factual assumptions:

· That operators engage in sham transactions to avoid liability for a civil money penalty in a material number of cases.

· That reviewing each individual case to determine whether it is a sham would be administratively difficult or impossible.

· That imposing liability on a successor for the defaults of the predecessor, and relieving the latter of its liability, will persuade the predecessor to comply with quality standards.

· That the successor can protect itself from any economic liability for the penalty by adjusting the purchase price.

· That refusing to accept assignment of the original provider agreement is a viable means to avoid liability for the penalty.

Those assumptions rest on pure speculation. Because HCFA's policy is the product of informal agency action, rather than notice and comment rulemaking or adjudication, no one (including Mr. Tirone) has the slightest idea whether any of those assumptions is correct.

The complexity of modern society means that Congress must delegate substantial authority to administrative agencies. When those agencies act informally, some form of meaningful judicial review is essential to hold them accountable for their decisions. In the long run, such review will produce fewer contested rulings rather than more. The knowledge that a court will

provide meaningful review gives the agency a substantial incentive to act reasonably rather than arbitrarily – the end result being better and fairer public policy.

III. HCFA's Successor Liability Policy Is An Irrational Policy That Will Irreparably Injure The Very People It Is Supposed To Help.

Apart from the importance of resolving the standard of judicial review of informal agency action, the Court should consider HCFA's policy on the merits. That policy directly and adversely affects the health and safety – even the lives – of some of society's most defenseless people: the frail elderly residents of nursing homes.

As noted, the sole purpose of a civil money penalty "is to ensure prompt compliance with program requirements." 42 C.F.R. § 488.402(a). HCFA thought that the penalty would "motivate providers to achieve and maintain substantial compliance before termination becomes necessary." 59 Fed. Reg. at 56177. Closing a nursing home and transferring its elderly residents was a "last resort" that should be undertaken "only in an emergency." 59 Fed. Reg. at 56196.

Assessing and collecting a civil money penalty from the delinquent operator of a facility does encourage compliance with quality standards. The desire to avoid penalties may deter the operator from allowing the facility to deteriorate in the first place; if violations occur, the desire to minimize penalties provides a strong incentive for prompt corrective actions. Collecting the penalty from a successor who – as here – was twice removed from and has absolutely no connection with

that predecessor cannot possibly serve that purpose. Because the new operator cannot control the predecessor at the time of the violation, it cannot possibly prevent deterioration of the facility in the first place, or minimize the amount of time that the facility remains out of compliance.

The only effect that the HCFA policy will have on deterrence is negative. Under the HCFA policy, an assignment of the provider agreement transfers liability for civil money penalties to the new operator, and relieves the predecessor of its liability for the penalty. Thus, the HCFA policy reduces the deterrent effect on the predecessor operator – a wildly irrational result that is directly contrary to the stated purpose of civil money penalties.

The most likely effect of the HCFA policy on new operators is to deter them from taking over troubled facilities, thereby forcing those facilities to close. If the facilities must close, the elderly residents must move. Medical literature has documented that moving frail elderly people from what they regard as their homes causes delirium and confusion and can endanger their lives. Numerous cases have so held. *Yaretsky v. Blum*, 629 F.2d 817, 821 (2d Cir. 1980), *rev'd on other grounds*, 457 U.S. 991 (1982) ("transfer of elderly patients . . . carries with it the undeniable possibility of emotional and psychological harm"); *Lexington Mgmt. Co. v. Missouri Dep't of Social Services*, 656 F. Supp. 36, 41 (W.D. Mo. 1986) (transfer trauma causes "refusal to eat, a general sense of disorientation, or a loss of one's will to live," and "has even been directly linked to the deaths of some nursing home residents"). The HCFA policy turns the last resort into a first resort – again a wildly

irrational result that is directly contrary to the purpose of the penalty.

The Eighth Circuit's assumption that adjustments to the purchase price of the facility will offset any unpaid penalty, App. 9, is pure speculation. At a maximum of $10,000 a day, a civil money penalty could quickly exceed the total economic value of the facility. In that case, even a purchase price of zero will not offset the penalty and an intelligent operator will simply refuse to take over the facility.

The Eighth Circuit also suggested that a new operator could avoid the penalty by applying for a new provider agreement. App. 7. It is sheer speculation to assume that a new operator will take this route rather than simply refusing to take over a troubled facility. As the Tirone memorandum itself recognizes, this route "means termination from the Medicare program, a serious and ordinarily undesirable consequence." App. 34. The survey and certification process incident to a new provider agreement takes several months to complete, during which time the facility is providing services for which it cannot ever obtain reimbursement from the government. Rather than incur that loss, an intelligent operator will simply refuse to take over a troubled facility or decline to participate in the Medicare program at all.

The HCFA policy makes collection of civil money penalties an end in itself, rather than a means to the end that Congress desired. Since no one has ever seriously analyzed nor tested the Eighth Circuit's assumptions about how the market for nursing facilities will operate, there is a substantial risk that those assumptions may be wrong. If the panel's assumptions are wrong, the

people who will bear the consequences are the frail elderly residents of the nursing homes that close. A policy that creates such risks in exchange for no discernible benefit is irrational.

The only other published opinion on this issue of which counsel is aware is *Texas Dep't of Human Services v. Kemp Health Services, Inc.*, 993 S.W.2d 698 (Tex. App. 1999), which interprets an analogous Medicaid regulation, 42 C.F.R. § 442.14(b). Like § 489.18, § 442.14(b) requires the assignee of a provider agreement to take it "subject to all applicable statutes and regulations and to the terms and conditions under which it was originally issued." The Texas Department of Human Services enacted a regulation imposing successor liability for civil money penalties. The Texas court held that § 442.14(b) prohibited successor liability:

> The sanctions imposed against LTC [the predecessor] were not a part of LTC's contract as "it was originally issued," although they arose from violations of LTC's contract obligations. . . .
>
> The federal regulation plainly forbids the Department's imposing against a succeeding owner sanctions imposed against the former owner.

993 S.W.2d at 702. *Kemp* is irreconcilable with the Eighth Circuit's opinion in the instant case.

The disposition of this case will have real human consequences for real human beings. HCFA's successor liability policy creates a substantial risk of harm to the millions of frail elderly residents of nursing homes, and it does so for no discernible benefit. The source of that foolish policy is the absence of any institutional check on

informal agency action. Given the disarray in this Court's opinions, only this Court can correct the problem.

Conclusion

For these reasons, Deerbrook respectfully prays that the Court issue its writ of certiorari to the United States Court of Appeals for the Eighth Circuit.

Respectfully Submitted,

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APPENDIX

Appendix

United States Court of Appeals

FOR THE EIGHTH CIRCUIT

No. 99-4324

Deerbrook Pavilion, LLC,
Appellant,
v.

Donna E. Shalala, Secretary, U.S. Department of Health & Human Services; United States Department of Health and Human Services; Nancy-Ann Mm Deparle, Administrator, Health Care Financing Administration; Joe L. Tilghman, Regional Administrator, Health Care Financing Administration; Thomas W. Lenz, Associate Regional Administrator for Division of Medicaid and State Operations; Health Care Financing Administration; Gary J. Stangler, Director, MO Department of Social Services; Missouri Department of Social Services; Gregory J. Vadner, Director, MO Department of Medical Services; Missouri Division of Medical Services,

Appellees.*

Appeal from the United States
District Court for the
Western District of Missouri.
Submitted: September 15, 2000
Filed: December 26, 2000

Before HANSEN, HEANEY and MORRIS SHEPPARD ARNOLD, Circuit Judges.

HEANEY, Circuit Judge.

This case concerns successor liability for civil monetary penalties (CMPs) imposed by the Health Care Financing Administration (HCFA) on a skilled nursing facility (nursing home). HCFA imposed CMPs on a nursing home and, after it was bought by Deerbrook Pavilion, L.L.C. (Deerbrook), HCFA sought to collect the penalties from Deerbrook. Deerbrook then brought a complaint in the district court, alleging that the federal and state defendants lacked the authority to impose CMPs on it, and that doing so was a violation of due process. The district court granted the defendant's motion to dismiss, *see Deerbrook Pavilion, L.L.C. v. Shalala*, No. 99-4179-CV-C-SOW-ECF (W.D. Mo., Nov. 4, 1999), and this appeal followed. As we agree with the district court that HCFA has the authority to impose a civil monetary penalty on Deerbrook, we affirm the dismissal of the complaint.

I. BACKGROUND

In reviewing a Federal Rule of Civil Procedure 12(b)(6) dismissal, we must assume all of the facts alleged in the complaint to be true and affirm only if it is clear that no relief can be granted based on those allegations. *See Alexander v. Peffer*, 993 F.2d 1348, 1349 (8th Cir. 1993). We review a 12(b)(6) dismissal de novo. *See Hilton v. Pine Bluff Pub. Schools*, 796 F.2d 230, 231 (8th Cir. 1986). On a motion to dismiss, a court must primarily consider the allegations contained in the complaint, although matters of public and administrative record referenced in the complaint may also be taken into account. *See Jackson v. City of Columbus*, 194 F.3d 737, 745 (6th Cir. 1999); *Sebastain v. United States*, 185 F.3d 1368, 1374 (Fed. Cir. 1999).

Prior to Deerbrook's tenure as operator of the nursing home in question, government auditors discovered serious problems that threatened the health and safety of the facility's elderly and infirm residents. The facility had numerous violations of basic sanitary standards and was also cited for neglect to the residents' basic needs. The auditors determined that these conditions put the residents' health in immediate jeopardy and imposed CMPs, which at one period amounted to $6,100 per day. After a period from March 22, 1996 to September 5, 1996, in which surveys revealed repeated violations, the facility was brought into substantial compliance. In total, there were $419,700 in CMPs assessed against the facility.

On January 10, 1997, Deerbrook began operating the facility.[3] Instead of applying for a new medicare provider agreement, Deerbrook continued the agreement used by its predecessors. HCFA sought to collect the CMPs from the original operator that had incurred the penalties, but that corporation was dissolved. HCFA then sought to collect the CMPs from Deerbrook.

Deerbrook then filed a complaint in district court asserting that HCFA did not have the authority to impose successor liability and that collection of CMPs against it would violate due process. The federal defendants responded that unpaid CMPs "travel" with an existing provider agreement and that a new operator is subject

3 Deerbrook represents that it is a separate entity from the original operator of the nursing home that accrued the CMPs. The record reflects that Deerbrook's counsel also represented the original operator. Although this overlapping representation might present some question of entanglement between the two organizations, for purposes of a motion to dismiss we must take the allegations of Deerbrook's complaint to be true.

to the regulatory history of the facility. The district court granted the federal defendants' motion to dismiss. On September 1, 1999, another entity, White Oak Terrace, L.L.C. (White Oak), assumed control of the facility.

II. PROCEDURAL ISSUES

A. Jurisdiction

We conclude that the district court had jurisdiction. As the district court held, Deerbrook's claims arose from the Fifth Amendment to the Constitution within the meaning of 28 U.S.C. § 1331, and the Administrative Procedure Act waives the government's sovereign immunity. *See* 5 U.S.C. § 702.

The federal defendants now argue that Deerbrook should have administratively contested the imposition of the CMPs on its predecessor before filing a complaint in the district court. Relying on *Shalala v. Illinois Council on Long Term Care, Inc.*, 529 U.S. 1 (2000), they contend that Deerbrook's failure to seek agency review of the CMP deprived the district court of jurisdiction. However, in this litigation Deerbrook is not contesting whether the prior operator's conduct warranted a CMP, or that the amount of the CMP was incorrectly assessed. Rather, Deerbrook is contesting whether it is liable for a prior operator's CMP. These are two separate issues. It is questionable whether Deerbrook even had the standing (or the incentive) to intervene in contesting the imposition of CMPs on its predecessor. Therefore, the district court had jurisdiction to hear the case.

B. Mootness

Both the federal and state defendants argue that this appeal is moot because White Oak has now taken over the operation of the facility from Deerbrook.

A case is moot when it is "impossible for the court to grant any effectual relief whatever." *Church of Scientology v. United States*, 506 U.S. 9, 12 (1992) (internal quotation omitted). Deerbrook's complaint sought a declaratory judgment stating that collecting CMPs from a successor operator violated due process. Deerbrook also sought to enjoin the federal and state defendants from collecting the CMPs by withholding Medicare and Medicaid payments. Before the court had an opportunity to rule on the issue, the federal defendants withheld a $29,000 Medicare payment to satisfy the CMPs partially. Deerbrook filed a motion for a temporary restraining order citing the withholding of the $29,000.

It is clear the federal defendants withheld $29,000 in payments to satisfy the CMPs. Although the complaint itself does not ask for monetary damages, restitution of the $29,000 that was withheld was clearly contemplated in the motion for a temporary restraining order. *Cf. Doe v. United States Dept. of Justice*, 753 F.2d 1092, 1104 (D.C. Cir. 1985) (holding that claim should not be dismissed if some type of relief, not limited to relief asked for in the complaint, can be awarded). That White Oak now operates the facility does not change the fact that the federal defendants withheld $29,000 from Deerbrook on the basis of its predecessor's violations. The dispute has not become academic, as some form of meaningful relief is possible. *See Church of Scientology*, 506 U.S. at 12; *In re Grand Jury Subpoenas*, 78 F.3d 1307, 1311 (8th Cir. 1996).

As to the state defendants, there is no longer a live controversy. It is clear from the record that the state has never collected nor threatened to collect any CMPs from

Deerbrook. As Deerbrook no longer operates the facility, and the $419,700 CMP was generated during the tenure of another operator, the state can no longer withhold any monetary payments to Deerbrook.

III. SUCCESSOR LIABILITY

Although Deerbrook has claimed a number of Fifth Amendment violations, the central issue in this case is whether HCFA has the ability to impose CMPs on subsequent nursing home owners. We conclude that HCFA has such authority under the regulations.

Congress delegated the Department of Health and Human Services (HHS) broad authority regarding the imposition of remedies for statutory violations in skilled nursing facilities. The Secretary of HHS was delegated the authority to "specify criteria, as to when and how each of such remedies [including CMPs] is to be applied, the amounts of any fines, and the severity of each of the remedies." 42 U.S.C. § 1395i-3(h)(2)(B)(iii) (2000).

The regulations provide that when a change of ownership occurs, and the new owner assumes the existing provider agreement, the new owner assumes the agreement subject to its prior terms and conditions. "An assigned agreement is subject to all applicable statutes and regulations and to the terms and conditions under which it was originally issued including, *but not limited to* . . . (1) Any existing plan of correction. (2) Compliance with applicable health and safety standards . . ." 42 C.F.R. § 489.18 (2000) (emphasis added). Just as an existing plan of correction carries over to the subsequent owner, so too do the CMPs when the new owner accepts transfer of the existing provider agreement. The agency's commentary on this issue is clear that a

"facility's prior compliance history should be considered regardless of a change in ownership. A facility is purchased 'as is.' The new owner acquires the compliance history, good or bad, as well as the assets." 59 Fed. Reg. 56,174 (1994). The new owner can always apply for a new provider agreement.

As several commentators have pointed out, since 1994 HCFA has taken the view that there is successor liability in an effort to curb fraud and sham transactions in the nursing home industry. *See* Paul R. De Muro & Esther R. Scherb, *Steering Around Successor Liability in Health Care Transactions*, 1129 PLI/Corp 23, 30 (June 1999); Greg Radinsky, *How Health Care Attorneys Can Discern Vernon, Successor Liability and Settlement Issues*, 44 St. Louis U. L. J. 113, 123-124 (2000). Specifically, the agency put forth a memorandum in 1994 that emphasized successor liability regarding plans of correction and CMPs. *See* HCFA Memorandum on Commerce Clearinghouse Report of Court Ruling Regarding Transfer of Provider Agreement, Anthony J. Tirone to Spencer K. Ericson (Dec. 29, 1994). An agency's interpretation of its own regulations is entitled to great deference. *See Baker v. Heckler*, 730 F.2d 1147, 1149 (8th Cir. 1984); *Abbott-Northwestern Hosp., Inc. v. Schweiker*, 698 F.2d 336, 340 (8th Cir. 1983).

The Fifth Circuit addressed a virtually identical issue in *United States v. Vernon Home Health, Inc.*, 21 F.3d 693 (5th Cir. 1994). There, the new owner had entered into a contract to buy the assets, but not the liabilities, of the previous owners. The new owner assumed the existing provider agreement. The prior owner had received an overpayment from Medicare reimbursements. *See id.* at 694. The Fifth Circuit held that the new owner was

jointly and severally liable with the old owner for the Medicare overpayments. The court reasoned that 42 C.F.R. § 489.18(d) imposed a requirement that the new owner was liable for any overpayment. *See id.* at 696.

Although Deerbrook attempts to distinguish *Vernon* on the basis that it involved an overpayment and this case involves CMPs, we do not view this distinction as significant. Both cases involve monetary liability for the new operator. Here, Deerbrook assumed the existing provider agreement under which its predecessors incurred CMPs. CMPs were imposed for noncompliance with quality of care standards, *see* 42 U.S.C. § 1395i-3(h)(2)(B)(ii) (2000), and an assigned agreement is taken subject to all the terms and conditions under which it was issued, *see* 42 C.F.R. § 489.18(d) (2000). Therefore, following the logic of *Vernon*, the district court correctly held that Deerbrook was liable for the CMPs. *See Deerbrook Pavilion*, No. 99-4179-CV-C-SOW-ECF, slip op. at 7.

We are unpersuaded by Deerbrook's argument that successor liability for CMPs frustrates statutory intent or constitutes bad public policy. According to the federal defendants, HCFA imposes CMPs to ensure compliance with quality care standards. *See* 42 U.S.C. § 1395I-3(h)(2) (2000). That goal would be frustrated if nursing home operators were able to avoid CMPs by engaging in sham transfers. In addition, collection of CMPs from successors allows the replenishment of the Medicare trust finds when a previous operator dissolves or otherwise becomes judgment-proof, as in this case.

We are also not convinced by Deerbrook's argument that successor liability will lead some nursing homes to close for the lack of a buyer willing to pay the CMPs

owed. It appears to us that any amount of unpaid fines would ordinarily be reflected in a lower purchase price for the facility. Surveys of facilities are matters of public record, *see* 42 U.S.C. § 1395I-3(g)(5)(A)(2000), and checking a facility's regulatory history is an important due diligence task. Further, a new operator is free to apply for a new provider agreement for the facility, in which case it would not be liable for the prior owner's CMPs. *See Vernon*, 21 F.3d at 696.

Because HCFA has the authority to impose CMPs on Deerbrook, there has been no statutory or constitutional violation. We therefore affirm the opinion of the district court dismissing Deerbrook's complaint.

MORRIS SHEPPARD ARNOLD, Circuit Judge, dissents.

A true copy.

Attest:

CLERK, U. S. COURT OF APPEALS, EIGHTH CIRCUIT.

No. 99-4324

IN THE UNITED STATES COURT OF APPEALS

FOR THE EIGHTH CIRCUIT

DEERBROOK PAVILION, L.L.C.,
Plaintiff/Appellant,

vs.

DONNA E. SHALALA, et al.,
Defendants/Appellees

PETITION FOR REHEARING EN BANC

Deerbrook Pavilion, LLC (Deerbrook) respectfully prays that the Court rehear this case en banc. As grounds for this relief, Deerbrook states:

1. The panel opinion both creates and continues a direct conflict in this Court's precedents on the deference due to an agency's informal interpretation of its own regulations. The panel opinion holds that such interpretations are "entitled to great deference." Slip Op. at 7. *In re Old Fashioned Enterprises*, ___ F.3d ___, 2001 WL 10628 (8th Cir. 2001), and *King v. Morrison*, 231 F.3d 1094 (8th Cir. 2000), hold that such interpretations are "not entitled to substantial deference."

2. The panel opinion presents two issues of such exceptional importance as to warrant en banc review:

> A. What level of judicial deference is due to informal agency action that interprets the applicable statutes and/or agency panel's "great deference" standard permits an agency to justify its actions

through a self-serving memorandum without meaningful judicial review. By definition, that means the agency is essentially unaccountable for its actions.

B. Whether the Health Care Financing Administration (HCFA) has legal authority to collect a civil money penalty from a successor in interest to a nursing home provider agreement, when the successor bore no responsibility for the conditions that caused the penalty? The purpose of the civil money penalty is to deter operators from falling below minimum quality standards. Since the successor cannot control the original operator's actions at the time of the violation, successor liability cannot possibly serve that purpose. Such liability can only act as a strong deterrent to a competent new operator taking over a troubled facility.

3. The panel opinion was issued on December 26, 2000. Judge Heaney wrote the opinion and Judge Hansen concurred. Judge Morris Arnold dissented without opinion.

4. To participate in the Medicare or Medicaid program, a facility must have a provider agreement. In 1996, an entity known as Deerbrook Nursing Center, Inc. (Nursing Center) had a provider agreement for a skilled nursing facility that it leased from its owner. Deerbrook has no connection whatever with Nursing Center. In April 1996, the Missouri Division of Aging concluded that Nursing Center did not comply with various health and safety standards. As a result, HCFA assessed a civil money penalty against Nursing Center.

5. In July 1996, Nursing Center assigned its lease and its provider agreement to Deerbrook Healthcare, Inc.

(Healthcare). Deerbrook has no connection whatever with Healthcare. Healthcare restored the facility to acceptable levels of care and HCFA ended the civil money penalty in September 1996. The penalties against Nursing Center and Healthcare totaled $419,700. None of those penalties was assessed against Deerbrook.

6. In January 1997, Healthcare assigned the lease and the provider agreement to Deerbrook in an arms-length transaction. In July 1999, HCFA informed Deerbrook that Deerbrook, as successor to Nursing Center and Healthcare, was responsible for the entire $419,700 civil money penalty. The basis for HCFA's position is neither a statute nor a regulation. Rather, it is an informal memorandum (the Tirone memorandum) written in 1994 by a HCFA bureaucrat. Pursuant to that policy, HCFA withheld approximately $29,000 in reimbursements due to Deerbrook.

7. Later in 1999, Deerbrook assigned the lease and the provider agreement to White Oak Terrace, LLC. In its brief, HCFA argued that this assignment mooted the case. The necessary corollary of this position is that the assignment of the provider agreement divests the predecessor of any liability for civil money penalties and transfers that liability to the successor.

8. The foundation of the panel opinion is the Tirone memorandum, to which the opinion affords "great deference." Slip Op. at 7. No statute expressly authorizes HCFA to collect a civil money penalty from a successor. The statute under which it purported to act allows HCFA to deduct penalties from sums "due to the person against whom the penalty or assessment has been assessed." 42 U.S.C. § 1320a-7a(f). Since no penalty was assessed against Deerbrook, that statute cannot authorize HCFA to collect it from Deerbrook.

9. Similarly, no regulation expressly authorizes HCFA to collect a civil money penalty from a successor. The regulation quoted in the opinion provides only that the successor takes the provider agreement "'subject to all applicable statutes and regulations and to the terms and conditions under which it was originally issued.'" Slip Op. at 6, *quoting* 42 C.F.R. § 489.18. This begs the question whether a civil money penalty is one of the "terms and conditions" of the original provider agreement, and whether the "applicable statutes and regulations" so provide.

10. The Tirone memorandum does not, in so many words, adopt a policy of successor liability for civil money penalties. Rather, it recites that HCFA has ***considered proposing*** a rule that would so provide. App. 76, *citing* 59 Fed. Reg. 20387 (April 25, 1994). Beyond that, "we can say nothing more except that we expect the [notice of proposed rulemaking] to be published in the Federal Register in several months, and that there will be a 60-day public comment period." App. 76. Those expectations were not satisfied. HCFA did not publish any notice of proposed rulemaking or any proposed formal rule, nor did it ever adopt any such rule.

11. Thereafter, HCFA twice indicated an intention to propose a formal rule under which civil money penalties would be "automatically assigned to a new owner." 61 Fed. Reg. 23008 (May 13, 1996); 64 Fed. Reg. 21266 (April 26, 1999). On neither of these occasions did HCFA even propose a formal rule, let alone adopt one. Thus, the "policy" for which HCFA seeks great deference is nothing more than a summary of HCFA's intent to propose a rule — an intent that was never fulfilled.

12. In this Circuit, there are at least two, and possibly three, competing lines of authority on the deference due to informal agency action like the Tirone memorandum. The first approach — which the panel opinion adopted — gives informal agency action essentially the same deference that is given to a formal regulation. The ostensible basis for this line of authority is *Chevron U.S.A. Inc. v. Natural Resources Defense Council. Inc.*, 467 U.S. 837 (1984). *Chevron* held that, if the statute is silent or ambiguous about an issue, the agency has authority "to elucidate a specific provision of the statute by *regulation*." 467 U.S. at 844 (emphasis added). The Courts will afford that regulation "controlling weight" unless it is "arbitrary, capricious, or manifestly contrary to the statute." *Id.* A number of Eighth Circuit cases have misapplied *Chevron* to give the same deference to informal agency action that *Chevron* gives to regulations. Those cases include *Love v. Tippy*, 133 F.3d 1066, 1069 (8th Cir.), *cert. denied*, 524 U.S. 956 (1998), *Vue v. I.N.S.*, 92 F.3d 696, 699 (8th Cir. 1996), and the panel opinion in the instant case.

13. The source of the second line of authority is *Skidmore v. Swift & Co.*, 323 U.S. 134, 140 (1944). Last spring, in *Christensen v. Harris County*, ___ U.S. ___, 146 L.Ed.2d 621 (2000), the Supreme Court explained the basis for *Skidmore* deference:

> Interpretations such as those in opinion letters — like interpretations contained in policy statements, agency manuals, and enforcement guidelines, all of which lack the force of law — do not warrant Chevron-style deference. Instead, interpretations contained in formats such as opinion letters are "entitled to respect" under our decision in Skidmore

but only to the extent that those interpretations have the "power to persuade".

146 L.Ed.2d at 631. Eighth Circuit cases applying *Skidmore* deference to informal agency action – and reversing the agency – include *Henson v. Pulaski County Sheriff Dep't*, 6 F.3d 531, 535 (8th Cir. 1993), and *Reich v. Delcorp. Inc.*, 3 F.3d 1181 (8th Cir. 1993).

14. The third possible approach is the *Old Fashioned Enterprises* approach: "an agency's interpretation which is not subjected 'to the rigors of notice and comment' is not entitled to substantial deference." 2001 WL 10628, *quoting King v. Morrison*, 231 F.3d 1094, 1097 (8th Cir. 2000)) This approach may not differ materially from *Skidmore* deference; the Tenth Circuit opinions on which *Old Fashioned Enterprises* and *King* rely both employ *Skidmore* deference. *United States v. 162 Megamania Gambling Devices*, 231 F.3d 713, 719 (10th Cir. 2000); *Fristoe v. Thompson*, 144 F.3d 627, 631 (10th Cir. 1998). Assuming that *Old Fashioned Enterprises* and *King* are simply additional illustrations of *Skidmore* deference, they are as directly inconsistent with the panel opinion as *Henson* and *Reich*.

15. Deerbrook submits that, as a matter of policy, the *Skidmore* approach is the only appropriate standard of judicial review of informal agency action. A rule enacted after notice and comment is much more reliable than ad hoc, informal agency action. Notice and comment rulemaking gives "all potentially affected members of the public ... an opportunity to participate" in the process. K. Davis & R. Pierce, *Administrative Law Treatise*, § 6.7 at 262 (3d Ed. 1994). That participation gives the agency an opportunity to make a truly informed decision on a complete factual record:

[P]arties have incentives to include in their comments studies and affidavits of experts addressing such issues as (1) the frequency of occurrence of various factual patterns, (2) the likely efficacy of alternative rules in shaping conduct, (3) the cost of compliance with alternative rules, and (4) the practical problems inherent in implementing or enforcing alternative rules in varying factual contexts.

Id. It is appropriate for courts to defer to administrative action based on a complete factual record and a thoroughly analyzed response. The Tirone memorandum contains neither facts nor analysis. It is not appropriate to defer to informal agency action that does no more than summarize an intent to propose a regulation that was neither formally proposed nor adopted.

16. The instant case is a perfect illustration of the wisdom of the *Skidmore* approach. The panel opinion's conclusions rest on a host of unproven factual assumptions:

- That operators engage in sham transactions to avoid liability for a civil money penalty in a material number of cases.
- That reviewing each individual case to determine whether it is a sham would be administratively difficult or impossible.
- That imposing liability on a successor for the defaults of the predecessor, and relieving the latter of its liability, will persuade the predecessor to comply with quality standards.
- That the successor can protect itself from any economic liability for the penalty by adjusting the purchase price.

- That refusing to accept assignment of the original provider agreement is a viable means to avoid liability for the penalty.

Because the Tirone memorandum is the product of informal agency action, neither HCFA nor the panel can possibly know whether any of those assumptions is correct.

17. The proper standard of review of informal agency action is an issue of great public importance. In many cases, as in this one, it is case-dispositive. Deerbrook submits that *Skidmore* deference is essential in order to hold agencies accountable for their actions. By definition, the notice and comment process cannot hold agencies accountable when they act informally. If the courts review such action with "great deference," there is no institutional mechanism to assure that anyone takes a hard look at a proposed, unpromulgated policy. HCFA's successor liability policy is a perfect illustration of the disaster that results from such an approach. HCFA's policy relieves the guilty predecessor of any liability for the civil money penalties and transfers that liability to the entirely innocent successor. That is self-evidently irrational.

18. Wholly apart from the intra-circuit conflict, the Court should consider the merit of the HCFA policy. The resolution of this appeal will directly affect the health and safety – even the lives – of some of society's most defenseless people: the frail elderly residents of nursing homes.

19. Contrary to the panel opinion's unsupported assertion, Slip Op. at 8, the purpose of a civil money penalty is not to enrich the federal government. Rather, accord-

ing to HCFA, its sole purpose "is to ensure prompt compliance with program requirements." 42 C.F.R. § 499.402(a). HCFA thought that the penalty would "motivate providers to achieve and maintain substantial compliance before termination becomes necessary." 59 Fed. Reg. at 56177. Closing a nursing home and transferring its elderly residents was a "last resort" that should be undertaken "only in an emergency." 59 Fed. Reg. at 56196. In affording great deference to HCFA's informal action, the panel opinion ignores the formal regulation that HCFA itself adopted.

20. Assessing and collecting a civil money penalty from the delinquent operator of a facility does encourage compliance with quality standards. The desire to avoid penalties may deter the operator from allowing the facility to deteriorate in the first place; if violations occur, the desire to minimize penalties provides a strong incentive for prompt corrective actions. Collecting the penalty from a successor who — as here — has absolutely no connection with the predecessor cannot possibly serve that purpose. Because the new operator cannot control the predecessor at the time of the violation, it cannot prevent deterioration of the facility in the first place, nor minimize the amount of time that the facility remains out of compliance.

21. Indeed, the only effect that the HCFA policy will have on deterrence is negative. Under the HCFA policy, an assignment of the provider agreement transfers liability for civil money penalties to the new operator, and relieves the predecessor of its liability for the penalty. Thus, the HCFA policy reduces the deterrent effect on the predecessor operator — a wildly irrational result that is directly contrary to the stated purpose of civil money penalties.

22. It is self-evident that the most likely effect of the HCFA policy on new operators is to deter them from taking over troubled facilities, thereby forcing those facilities to close. If the facilities must close, the elderly residents must move. Medical literature has documented that moving frail elderly people from what they regard as their homes causes delirium and confusion and can endanger their lives. App. 56 ¶ 6. Numerous cases have so held. *Yaretsky v. Blum*, 629 F.2d 817, 821 (2d Cir. 1980) ("transfer of elderly patients . . . carries with it the undeniable possibility of emotional and psychological harm"); *Lexington Mgmt.Co. v. Missouri Dep't of Social Services*, 656 F. Supp. 36, 41 (W.D. Mo. 1986) (transfer trauma causes "refusal to eat, a general sense of disorientation, or a loss of one's will to live," and "has even been directly linked to the deaths of some nursing home residents"). The HCFA policy turns the last resort into a first resort – again a wildly irrational result that is directly contrary to the purpose of the penalty.

23. The panel opinion's assumption that adjustments to the purchase price of the facility will offset any unpaid penalty, Slip Op. at 8, is pure speculation. At a maximum of $10,000 a day, a civil money penalty could quickly exceed the total economic value of the facility. In that case, even a purchase price of zero will not offset the penalty and an intelligent operator will simply refuse to take over the facility.

24. The panel opinion also suggested that a new operator could avoid the penalty by applying for a new provider agreement. Slip Op. at 8. It is sheer speculation to assume that a new operator will take this route rather than simply refusing to take over a troubled facility. As the Tirone memorandum itself recognizes, this route

"means termination from the Medicare program, a serious and ordinarily undesirable consequence." App. 74. The survey and certification process incident to a new provider agreement takes several months to complete, during which time the facility is providing services for which it cannot ever obtain reimbursement from the government. Rather than incur that loss, an intelligent operator will refuse to take over a facility against which a penalty has been assessed.

25. The HCFA policy makes collection of civil money penalties an end in itself, rather than a means to the end that Congress desired. Since no one has ever seriously analyzed the panel opinion's assumptions about how the market for nursing facilities will operate, there is a substantial risk that those assumptions may be wrong. If the panel's assumptions are wrong, the people who will bear the consequences are the frail elderly residents of the nursing homes that close. A policy that creates such risks in exchange for no discernible benefit is irrational.

26. The only published opinion on this issue of which counsel is aware is *Texas Dep't of Human Services v. Kemp Health Services. Inc.*, 993 S.W.2d 698 (Tex. App. 1999), which interprets an analogous Medicaid regulation, 42 C.F.R. § 442.14(b). Like § 489.18, § 442.14(b) requires the assignee of a provider agreement to take it "subject to all applicable statutes and regulations and to the terms and conditions under which it was originally issued." The Texas Department of Human Services enacted a regulation imposing successor liability for civil money penalties. The Texas court held that § 442.14(b) prohibited successor liability:

> The sanctions imposed against LTC [the predecessor] were not a part of LTC's contract as "it was originally issued," although they arose from violations of LTC's contract obligations.
>
> The federal regulation plainly forbids the Department's imposing against a succeeding owner sanctions imposed against the former owner.

993 S.W.2d at 702.

27. The undersigned counsel is well aware that it is a rare case that warrants en banc consideration. In 22 years of practice before this Court, I have filed a petition for rehearing en banc only twice. In *In re Ahlers*, 794 F.2d 388 (8th Cir. 1986), *rev'd*, 485 U.S. 197 (1988), five of the nine participating judges voted for rehearing; the tenth judge's recusal meant that the petition failed to collect a majority of active judges. In *In re Federal Fountain*, 143 F.3d 1138 (8th Cir. 1998), *rev'd* 165 F.3d 600 (8th Cir. en banc 1999), the Court granted rehearing and unanimously reversed the panel. The same result is appropriate in the instant case. Administrative law may not be the most interesting branch of the law, but the disposition of this case will have real human consequences for real human beings. Wholly apart from the obvious intra-circuit conflict, those human consequences deserve en banc review.

28. The panel opinion also held that the case was moot as to the state defendants. Deerbrook does not seek rehearing of that holding.

Wherefore, Deerbrook respectfully prays that the Court rehear this case en banc.

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Attorneys for Plaintiff/Appellant
Deerbrook Pavilion, L.L.C.

Certificate Of Service

The undersigned hereby certifies that a copy of the foregoing petition was forwarded this 9th day of February, 2001, by first class mail, postage prepaid, to:

Ronald Molteni, Esq.
Gail Vasterling, Esq.
Assistant Attorneys General
Office of Attorney General
Supreme Court Building
207 West High Street
P.O. Box 899
Jefferson City, MO 65102

Harry B. Mallin, Esq.
Assistant Regional Counsel
Office of General Counsel, Region VII
U.S. Department of Health & Human Services
601 East 12th Street, Room 1711
Kansas City, MO 64106

Andrew J. Lay, Esq.
Assistant United States Attorney
Office of United States Attorney
Charles Evans Whittaker Courthouse
400 East Ninth Street, 5th Floor
Kansas City, MO 64106

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Mark G. Arnold

UNITED STATES COURT OF APPEALS

FOR THE EIGHTH CIRCUIT

No. 99-4324

Deerbrook Pavilion, LLC,
Appellant,

v.

Donna E. Shalala, etc., et al.,
Appellees.

Order Denying Petition for

Rehearing and for Rehearing

En Banc

The petition for rehearing en bane is denied. Judge Bowman, Judge Loken, Judge Morris Sheppard Arnold, and Judge Bye would grant the petition.

The petition for rehearing by the panel is also denied.

(5128-010199)

March 22, 2001

Order Entered at the Direction of the Court:
Michael E. Gans

Clerk, U.S. Court of Appeals, Eighth Circuit

42 U.S.C. § 1395i-3(h):

(h) Enforcement process

(1) In general If a State finds, on the basis of a standard, extended, or partial extended survey under subsection (g)(2) of this section or otherwise, that a skilled nursing facility no longer meets a requirement of subsection (b), (c), or (d) of this section, and further finds that the facility's deficiencies -

(A) immediately jeopardize the health or safety of its residents, the State shall recommend to the Secretary that the Secretary take such action as described in paragraph (2)(A)(i); or

(B) do not immediately jeopardize the health or safety of its residents, the State may recommend to the Secretary that the Secretary take such action as described in paragraph (2)(A)(ii).

If a State finds that a skilled nursing facility meets the requirements of subsections (b), (c), and (d) of this section, but, as of a previous period, did not meet such requirements, the State may recommend a civil money penalty under paragraph (2)(B)(ii) for the days in which it finds that the facility was not in compliance with such requirements.

(2) Secretarial authority

(A) In general With respect to any skilled nursing facility in a State, if the Secretary finds, or pursuant to a recommendation of the State under paragraph (1) finds, that a skilled nursing facility no longer meets a requirement of subsection (b), (c), (d), or (e) of this section, and further finds that the facility's deficiencies –

(i) immediately jeopardize the health or safety of its residents, the Secretary shall take immediate action to remove the jeopardy and correct the deficiencies through the remedy specified in subparagraph (B)(iii), or terminate the facility's participation under this subchapter and may provide, in addition, for one or more of the other remedies described in subparagraph (B); or

(ii) do not immediately jeopardize the health or safety of its residents, the Secretary may impose any of the remedies described in subparagraph (B). Nothing in this subparagraph shall be construed as restricting the remedies available to the Secretary to remedy a skilled nursing facility's deficiencies. If the Secretary finds, or pursuant to the recommendation of the State under paragraph (1) finds, that a skilled nursing facility meets such requirements but, as of a previous period, did not meet such requirements, the Secretary may provide for a civil money penalty under subparagraph (B)(ii) for the days on which he finds that the facility was not in compliance with such requirements.

(B) Specified remedies The Secretary may take the following actions with respect to a finding that a facility has not met an applicable requirement:

42 U.S.C. § 1320a-7a:

(a) Improperly filed claims

Any person (including an organization, agency, or other entity, but excluding a beneficiary, as defined in subsection (i)(5) of this section) that –

(1) knowingly presents or causes to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency (as defined in subsection (i)(1) of this section), a claim (as defined in subsection (i)(2) of this section) that the Secretary determines –

(A) is for a medical or other item or service that the person knows or should know was not provided as claimed, including any person who engages in a pattern or practice of presenting or causing to be presented a claim for an item or service that is based on a code that the person knows or should know will result in a greater payment to the person than the code the person knows or should know is applicable to the item or service actually provided,

(B) is for a medical or other item or service and the person knows or should know the claim is false or fraudulent,

(C) is presented for a physician's service (or an item or service incident to a physician's service) by a person who knows or should know that the individual who furnished (or supervised the furnishing of) the service –

(i) was not licensed as a physician,

(ii) was licensed as a physician, but such license had been obtained through a misrepresentation of material fact (including cheating on an examination required for licensing), or

(iii) represented to the patient at the time the service was furnished that the physician was certified in a medical specialty by a medical specialty board when the individual was not so certified,

(D) is for a medical or other item or service furnished during a period in which the person was excluded from the program under which the claim was made pursuant to a determination by the Secretary under this section or under section 1320a-7, 1320c-5, 1320c-9(b) (as in effect on September 2, 1982), 1395y(d) (as in effect on August 18, 1987), or 1395cc(b) of this title or as a result of the application of the provisions of section 1395u(j)(2) of this title, or

(E) is for a pattern of medical or other items or services that a person knows or should know are not medically necessary;

(2) knowingly presents or causes to be presented to any person a request for payment which is in violation of the terms of (A) an assignment under section 1395u(b)(3)(B)(ii) of this title, or (B) an agreement with a State agency (or other requirement of a State plan under subchapter XIX of this chapter) not to charge a person for an item or service in excess of the amount permitted to be

charged, or (C) an agreement to be a participating physician or supplier under section 1395u(h)(1) of this title, or (D) an agreement pursuant to section 1395cc(a)(1)(G) of this title;

(3) knowingly gives or causes to be given to any person, with respect to coverage under subchapter XVIII of this chapter of inpatient hospital services subject to the provisions of section 1395ww of this title, information that he knows or should know is false or misleading, and that could reasonably be expected to influence the decision when to discharge such person or another individual from the hospital;

(4) in the case of a person who is not an organization, agency, or other entity, is excluded from participating in a program under subchapter XVIII of this chapter or a State health care program in accordance with this subsection or under section 1320a-7 of this title and who, at the time of a violation of this subsection –

(A) retains a direct or indirect ownership or control interest in an entity that is participating in a program under subchapter XVIII of this chapter or a State health care program, and who knows or should know of the action constituting the basis for the exclusion; or

(B) is an officer or managing employee (as defined in section 1320a-5(b) of this title) of such an entity;

(5) offers to or trasfers remuneration to any individual eligible for benefits under subchapter XVIII

of this chapter, or under a State health care program (as defined in section 1320a-7(h) of this title) that such person knows or should know is likely to influence such individual to order or receive from a particular provider, practitioner, or supplier any item or service for which payment may be made, in whole or in part, under subchapter XVIII of this chapter, or a State health care program (as so defined);

(6) arranges or contracts (by employment or otherwise) with an individual or entity that the person knows or should know is excluded from participation in a Federal health care program (as defined in section 1320a-7b(f) of this title), for the provision of items or services for which payment may be made under such a program; or

(7) commits an act described in paragraph (1) or (2) of section 1320a-7b(b) of this title;

shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than $10,000 for each item or service (or, in cases under paragraph (3), $15,000 for each individual with respect to whom false or misleading information was given; in cases under paragraph (4), $10,000 for each day the prohibited relationship occurs; or in cases under paragraph (7), $50,000 for each such act). In addition, such a person shall be subject to an assessment of not more than 3 times the amount claimed for each such item or service in lieu of damages sustained by the United States or a State agency because of such claim (or, in cases under paragraph (7), damages of not more than 3 times the total amount of remuneration offered, paid, solicited, or received, without regard to whether a portion of such remuneration was offered,

paid, solicited, or received for a lawful purpose). In addition the Secretary may make a determination in the same proceeding to exclude the person from participation in the Federal health care programs (as defined in section 1320a-7b(f)(1) of this title) and to direct the appropriate State agency to exclude the person from participation in any State health care program.

Memorandum

Director
Office of Survey and Certification, HSQB
Commerce Clearing House Report of Court Ruling Regarding
Transfer of Provider Agreement (Your Memorandum Dated
August 16)
Spencer K. Ericson
Associate Regional Administrator
Division of Health Standards and Quality
Region VIII

I am responding to your memorandum of August 16. You sent a Commerce Clearing House (CCH) abstract reporting the decision of the U.S. Court of Appeals for the Fifth Circuit in U.S. v. Vernon Home Health, Inc., and said, "If the courts continue to apply this logic, we will see a substantial increase in the number of changes of ownership accompanied by a request for a new provider number."

In Vernon, the court ruled that by accepting assignment of the provider agreement, the new owner of Vernon Home Health, Inc., was liable for overpayments incurred by the previous owner. The court based its decision on the following two points:

"... any purchase of assets that involves the assignment of the provider agreement is subject to the relevant statutory and regulatory conditions. One of these conditions is that adjustments are made to overpayments ..."

"Vernon II [the new owner] could have chosen not to accept the automatic assignment of the provider agreement. Indeed, the government acknowledges that the case would be different if Vernon II had not assumed Vernon I's [the previous owner's] provider number. In that case, Vernon II would have had to apply as a new applicant to participate in the Medicare program. But Vernon II accepted the automatic assignment because it did not want a break in service while it awaited approval ... By accepting that assignment, Vernon II agreed (albeit unknowingly) to accept the terms and conditions of the regulatory scheme. Thus, it is liable for the overpayments." 21 F.3d 693, 696 (5th Cir. 1994).

It is important to note that the CCH abstract is not entirely correct. The new owner became responsible for the liabilities in Vernon not (as the abstract says) "Because the successor corporation assumed the prior owner's provider number [emphasis added]," but because (as the above excerpt from the court's decision states) the new owner accepted assignment of the former owner's provider agreement; the provider number is just a bookkeeping device (or, as the court says, an "accounting procedure"). 21 F.3d at 696. It is the assignment of the provider agreement that transfers liabilities to a new owner. That is clear in the highlighted portions of the attached decision. The last highlighted paragraph does refer to the assignment of a provider number, but only insofar as it was assigned along with

the provider agreement. In the paragraph immediately preceding, the court says:

> The operative effect of section 498.18(d) [sic; correct reference is §489.18(d)] is that all assigned provider agreements [emphasis added] are subject to the rules and regulations of the Social Security Act. Thus, the state corporate law provisions recognizing Vernon II's right to purchase only assets is preempted by the federal law mandating that all assignments of provider agreements [emphasis added] be subject to federal terms and conditions. 21 F.3d at 696

Thus, it is the assignment of the provider agreement that makes a new owner liable for any overpayments made to a previous owner. Evidently, some new owners or prospective new owners read Vernon to mean that, if they can just obtain a different provider number than the one used by a previous owner, they will not be held liable for any overpayments made to the previous owner. They do not seem to realize that one can obtain a different provider number than the previous owner's only by obtaining a different provider agreement, and that the only way in which one can obtain a different provider agreement is to refuse to accept assignment of the previous owner's agreement, or, if the new owner has already accepted assignment, to voluntarily terminate it and apply to HCFA for participation in the Medicare program as a new provider.

Part of the problem stems from the fact that the terminology the court used in rendering its decision in Vernon is, unfortunately, not identical to the language HCFA uses in administering the Medicare program, and may be prone to misinterpretation. Specifically, he court

speaks in terms of "accepting assignment" and says that the new owner "could have chosen not to accept the automatic assignment of the provider agreement." This is true, but what it did not specifically spell out was that refusal to "accept assignment" means termination from the Medicare program, a serious and ordinarily undesirable consequence. HCFA manuals are unequivocal on this point:

"If the new owner indicates a desire not to participate in the program, advise the provider that it will be contacted by the RO and, if Medicaid is involved, by the State Medicaid agency within a few days."

SOM 3210.D.1.

"If, after a change of ownership, the successor does not wish to participate, the date of termination is the date the previous owner ceased doing business. However, coverage of beneficiary services extends until it is learned that the successor will not continue operations under a provider agreement."

ROM 4400.A.3.

"There may be a change of ownership in which the successor does not wish to participate as a provider. In such cases, the date of termination is fixed as the date the previous owner ceased doing business."

ROM 6450.C.

New owners must understand that, while they may "refuse assignment," if they still want to participate in the Medicare program, they are treated as any other new applicants to participate in the Medicare program; they must request to participate, they must undergo an

initial survey, meet the participation requirements, and be certified. They must understand that, until they are certified, there will be a period during which they will not receive Medicare payments. The length of this period is, to a large extent, based on how soon the State survey agency can schedule an initial survey after a request for participation is received, and upon whether the survey turns up any deficiencies that would preclude participation. (Sometimes providers are allowed to participate in the program with standard level or Level B deficiencies on the basis of an approved plan of correction.) They must also understand that, again, as with any new applicants, their request to participate may not be approved if they do not meet the participation requirements.

Nevertheless, it is possible that the amount of money lost by this hiatus in Medicare payments could be more than offset by avoiding responsibility for large overpayments and other liabilities incurred by previous owners. This decision is up to the prospective owner. As you know, the whole point of assigning provider agreements is to ensure continued payment when there is a change of ownership. However, if a new owner declines assignment of the provider agreement as a form of "insurance" against being held responsible for possible liabilities incurred by previous owners, he or she is free to do so.

Any new owner, prospective new owner, or attorneys representing them must be made aware of the above right to refuse assignment of the previous owner's provider agreement and of the consequences of such a decision, the most important and immediate of which is not being allowed to participate in the Medicare program without first having a separate survey and certi-

fication. This could result in a gap of services to the beneficiary and a loss of claims by the "new" provider. They must also be made aware of the fact that, if they choose to accept assignment, they may be held responsible for any overpayments made to a previous owner. Currently, each overpayment case which involves a change of ownership is handled on a case by case basis. First, HCFA attempts to recover overpayments from the owner to whom the overpayments were made. If that is not practicable or possible, HCFA takes up the matter with the new owner to consider whether the new owner should be held liable. Each case is decided on its own unique and individual merits.

If someone requests additional information on how a change of ownership affects overpayments, please refer him or her to—

Mr. Sam Guida
Director,
Division of Account Management and Collection
Bureau of Program Operations
Health Care Financing Administration
I -E-6 Meadows East Building
6300 Security Blvd.
Baltimore, MD 21207-5102

Mr. Guida may be reached on (410) 966-7495.

Another question that is coming up with increasing frequency is: What is the status of the Notice of Proposed Rulemaking (NPRM) on the effect of change of ownership on provider and supplier penalties, sanctions, and overpayments, and how would the proposed regulation (HSQ-215) affect current policy? The health

care community became aware of this proposed regulation on April 25, 1994, when an abstract was published in the Federal Register (59 FR 20387). The abstract is incorrect when it states that "all Medicare penalties and sanctions are automatically assigned to a new owner unless otherwise stated in the change of ownership [emphasis added]." Rather, the NPRM would clarify that the new owner is liable regardless of what the sales agreement states. Beyond correcting that mistake, we can say nothing more except that we expect the NPRM to be published in the Federal Register in several months, and that there will be a 60-day public comment period.

If you have any specific questions about the U.S. v. Vernon Home Health case, you may contact either of the following OGC attorneys:

Ms. Mary Salhus
Office of General Counsel
5309 Cohen Building
330 Independence Ave. S.W.
Washington, D.C. 20201-0001
Mr. Thomas Stuber
Office of General Counsel
500 East High Rise Building
6325 Security Blvd.
Baltimore, MD 21207-5187

Ms. Salhus may be reached at (202) 619-2794, and Mr. Stuber at (410) 965-8869.

We have attached two items you may find useful. The first is, a copy of the court's decision in Vernon, and the second depicts in chart form the consequences of a new

owner's accepting or rejecting assignment of the previous owner's provider agreement.

We ask that you continue to keep us advised of any activity related to the Vernon decision. If you have any questions, please contact Bill Roskey on (410) 966-0433.

Anthony J. Tirone

Attachments

cc: ARAs, Regions LVII and IX-X

Sam Guida

Mary Salhus

Thomas Stuber